MANGALORE **UNIVERSITY**

SYNOPSIS

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"Perceptions of Doctors on End-of-Life Care and Euthanasia with Reference to Terminally Ill Cancer Patients"

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I. INTRODUCTION

Terminal Cancer

A malignant, active illness that cannot be cured and is anticipated to cause death is referred to as a "terminal illness". The phrase is more frequently used in reference to progressing illnesses like cancer. (Ghuge Sharmila, 2015) The optimal care for advanced cancer patients requires a combination of approaches to control the underlying illness, optimize physical and emotional symptoms, and provide social support. (N. I. Cherny & Catane, 2003)

End-of-life Care

EoLC is caring for a patient with a terminal illness that focuses on symptom control, ensuring comfort, dignity, quality of life, and facilitating a peaceful end to life rather than pursuing treatments aimed at cure or prolongation of life. (Salins et al., 2018) The core concepts of dignity, autonomy, and relief from suffering frame the goal of End-of-Life Care (EoLC).

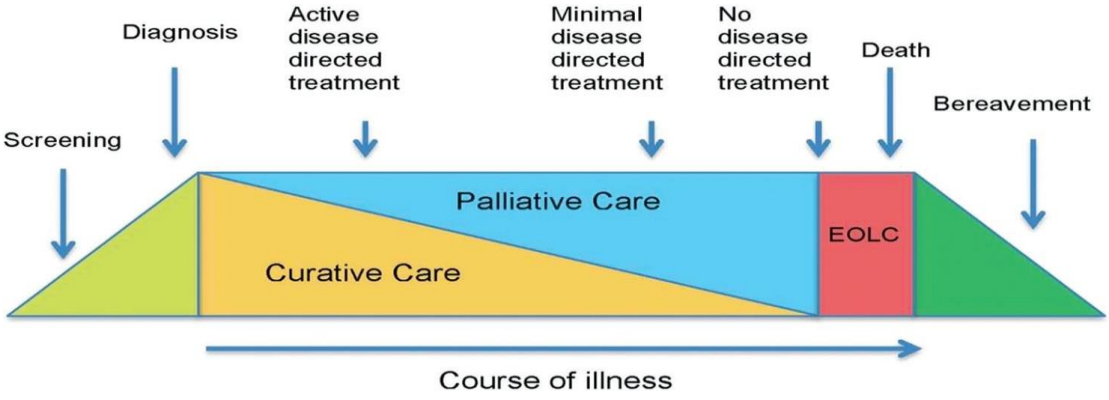

Figure 1.1: Representing the continuum of palliative care and end-of-life care in an illness trajectory. (Myatra et al., 2014)

Euthanasia

Euthanasia means ‘Good Death’, death without suffering. Suffering is used as the main argument to justify euthanasia since death can be seen as preferable to ongoing life with suffering, and therefore death alleviates suffering. (Annadurai et al., 2014; Sinha et al., 2012)

1.2 Background of the study

Every individual with a terminal illness at his/her end of life has the right to care with dignity and respect. What are the alternatives available to an individual at the end stage of cancer? How to alleviate the pain and suffering? It is always a matter of debate whether to assist in dying with dignity without suffering either by providing

qualitative End-of-Life Care till the natural death or by hastening the death through Euthanasia. Uncertainties at end-of-life definitions and practices are carefully negotiated by doctors in ways that are unique to each patient and their circumstances. There could be disagreements amongst doctors as well as between doctors, patients, and patient families regarding the proper care goal transition. (Trankle, 2013) Hence, the doctor plays a vital role in guiding the decision-making process. (Nash R Ryan & Shirilla Nicole, 2021) Hence it is pivotal to gain a greater understanding of the perceptions, attitudes, and decisions held by doctors in order to bring into the limelight the widespread unfamiliarity about end-of-life care and Euthanasia, to enhance the quality of life of individuals with terminal cancer.

1.3 Need of the Study

The role of the professionals caring for patients near the end of their lives is more important in ensuring that they receive the care and assistance they require. Doctors have to take into account not only professional, and legal requirements to what defines best practice (Shapiro, 2011) but also consider their own uniqueness in terms of personal beliefs, ethics and values when deciding on EoLC. (Adler, 2007) The increasing legalisation of euthanasia worldwide and the landmark verdict on Passive Euthanasia and advance directives or living wills from the Supreme Court of India make it important to understand related attitudes and practices. Dignity, autonomy, and alleviation from pain are the three main tenets in EoLC as well as in euthanasia advocacy, which are typically regarded as contradictory alternatives. Most of the studies are done either on End-of-Life care or Euthanasia. Very few studies are carried out taking into consideration both aspects. Hence the Researcher felt the need for the study by focussing on "Perceptions of Doctors on End-of-Life Care and Euthanasia with Reference to Terminally Ill Cancer Patients."

1.4 Research Questions:

- What are the perceptions of doctors on End-of-life Care and Euthanasia concerning patients with terminal cancer?
- Do the socio-demographic variables influence doctors' viewpoints on EoLC and Euthanasia?
- Are there differences in the perceptions of doctors on end-of-life care and euthanasia based on their speciality of practice or level of experience?

- Can a positive attitude of doctors towards end-of-life care lead to a negative attitude toward euthanasia, and vice versa?
- Do doctors' personal factors and perceptions of end-of-life care influence their views on Advance Directives or Advance Care Planning?
- Do doctors' personal factors and their perceptions on euthanasia influence their stance on the legalisation of euthanasia?

1.5 Conceptual Model

The model hypothetically illustrates the personal profile of doctors which includes bio-demographical factors, factors related to qualification, speciality of practice, area of expertise and professional experience that may influence or shape their perception on End-of-life Care and Euthanasia. The model also highlights the potential inverse relationship of positive perception towards EoLC may lead to negative perception towards Euthanasia or vice versa and the interconnectedness of these factors in influencing doctors' approach towards advance care planning or ADs and the broader debate about the legalisation of euthanasia.

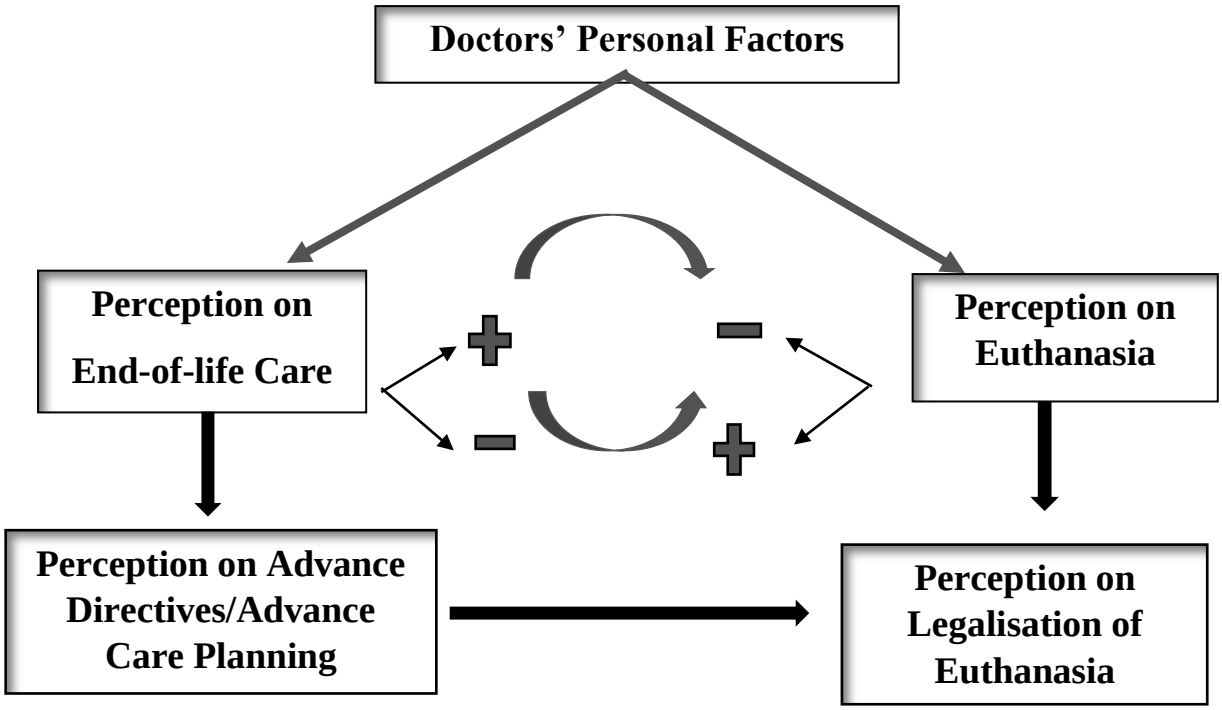
Doctors' Personal Factors
Perception on End-of-life Care
Perception on Euthanasia
Perception on Advance Directives/Advance Care Planning
Perception on Legalisation of Euthanasia

Figure 1.2: The conceptual model of the study

II REVIEW OF LITERATURE

The studies reviewed under eah section are shown through the Literature Map.

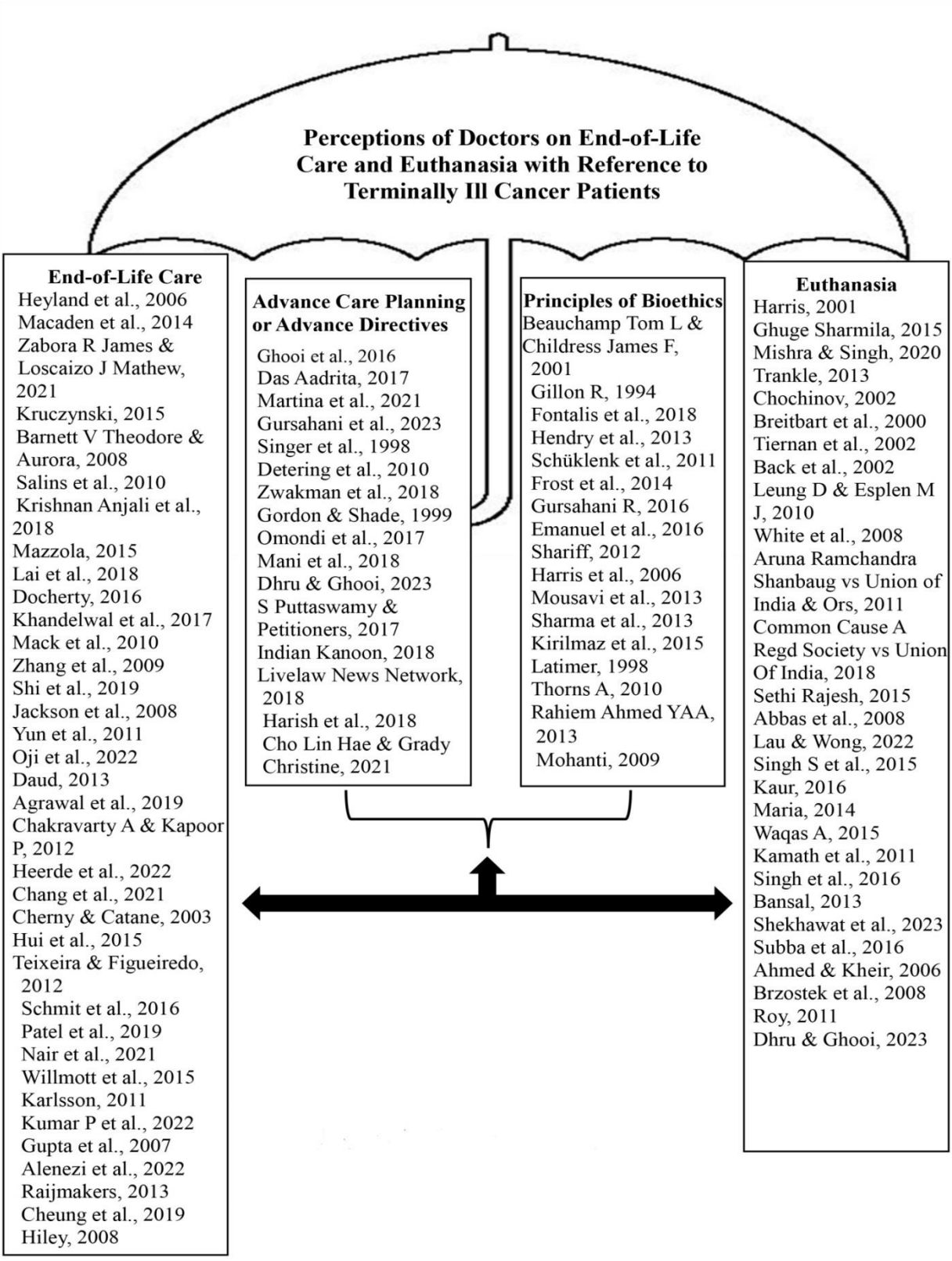
Perceptions of Doctors on End-of-Life Care and Euthanasia with Reference to Terminally Ill Cancer Patients
End-of-Life Care
Heyland et al., 2006
Macaden et al., 2014
Zabora R James & Loscaizo J Mathew, 2021
Kruczynski, 2015
Barnett V Theodore & Aurora, 2008
Salins et al., 2010
Krishnan Anjali et al., 2018
Mazzola, 2015
Lai et al., 2018
Docherty, 2016
Khandelwal et al., 2017
Mack et al., 2010
Zhang et al., 2009
Shi et al., 2019
Jackson et al., 2008
Yun et al., 2011
Oji et al., 2022
Daud, 2013
Agrawal et al., 2019
Chakravarty A & Kapoor P, 2012
Heerde et al., 2022
Chang et al., 2021
Cherny & Catane, 2003
Hui et al., 2015
Teixeira & Figueiredo, 2012
Schmit et al., 2016
Patel et al., 2019
Nair et al., 2021
Willmott et al., 2015
Karlsson, 2011
Kumar P et al., 2022
Gupta et al., 2007
Alenezi et al., 2022
Raijmakers, 2013
Cheung et al., 2019
Hiley, 2008
Advance Care Planning or Advance Directives
Ghooi et al., 2016
Das Aadrita, 2017
Martina et al., 2021
Gursahani et al., 2023
Singer et al., 1998
Detering et al., 2010
Zwakman et al., 2018
Gordon & Shade, 1999
Omondi et al., 2017
Mani et al., 2018
Dhru & Ghooi, 2023
S Puttaswamy & Petitioners, 2017
Indian Kanoon, 2018
Livelaw News Network, 2018
Harish et al., 2018
Cho Lin Hae & Grady Christine, 2021
Principles of Bioethics
Beauchamp Tom L & Childress James F, 2001
Gillon R, 1994
Fontalis et al., 2018
Hendry et al., 2013
Schüklenk et al., 2011
Frost et al., 2014
Gursahani R, 2016
Emanuel et al., 2016
Shariff, 2012
Harris et al., 2006
Mousavi et al., 2013
Sharma et al., 2013
Kirilmaz et al., 2015
Latimer, 1998
Thorns A, 2010
Rahiem Ahmed YAA, 2013
Mohanti, 2009
Euthanasia
Harris, 2001
Ghuge Sharmila, 2015
Mishra & Singh, 2020
Trankle, 2013
Chochinov, 2002
Breitbart et al., 2000
Tiernan et al., 2002
Back et al., 2002
Leung D & Esplen M J, 2010
White et al., 2008
Aruna Ramchandra Shanbaug vs Union of India & Ors, 2011
Common Cause A Regd Society vs Union Of India, 2018
Sethi Rajesh, 2015
Abbas et al., 2008
Lau & Wong, 2022
Singh S et al., 2015
Kaur, 2016
Maria, 2014
Waqas A, 2015
Kamath et al., 2011
Singh et al., 2016
Bansal, 2013
Shekhawat et al., 2023
Subba et al., 2016
Ahmed & Kheir, 2006
Brzostek et al., 2008
Roy, 2011
Dhru & Ghooi, 2023

Figure 2.1: Literature Map

For the present study, the Review of Literature is classified broadly into four sections. Some of the studies listed below

Literature Reviewed	Highlights
End-of-Life Care 35+ literature reviewed.	These studies explained doctors' knowledge and awareness, their beliefs, perceptions and attitudes about EoLC. The studies highlighted the importance of the EoLC and the barriers to providing optimal EoLC.
Euthanasia 25+ literature reviewed.	These studies described the attitudes of doctors towards euthanasia and PAS reasons for favouring and not favouring and need for Euthanasia, and its legalisation in India.
Advance Directives 15+ literature reviewed.	The studies described the need for Ads, their importance and the role of doctors in its implementation.
Bioethical Principles 15+ literature reviewed.	The studies explained the principles in medical care and requirements of providing various facets of EoL ethically by abiding by ethical principle

End-of-Life Care (EoLC)

A study on the analysis of end-of-life treatment and physician perceptions found a significant number of doctors felt unprepared and uncertain when treating patients who were near death. A decent palliative practice was more prevalent among doctors who routinely treated cancer patients than it was among those who did not. Good palliative care was provided to cancer patients than to non-cancerous disease patients. (Heerde et al., 2022) Despite the existence of palliative care in India since the middle of the 1980s, the growing demand has not matched the service delivery, as shown by the country's low coverage of morphine use which serves as a proxy indicator for access to palliative care.(Krishnan Anjali et al., 2018)

Euthanasia

The studies on Euthanasia exhibited different results. A Study conducted by Rajesh Sethi, showed, that the majority of the respondents supported legalising PAS and euthanasia on the grounds of respect for human life and individual autonomy. (Sethi Rajesh, 2015) In contrast to Sethi, a small percentage i.e., of 11.5% of Pakistani doctors and 25% of Indian doctors favoured euthanasia as a choice for cancer patients. The physicians' faith did not seem to be a deciding factor in favouring or not favouring euthanasia. (Abbas et al., 2008) Kaur in his study explains that physicians supported both active and passive euthanasia, and contemplated euthanizing terminally ill patients who are experiencing severe agony under certain conditions and

wished for a reliable mechanism to determine if a patient was qualified to receive euthanasia through a comprehensive law. (A. Kaur, 2016)

Advance Directives or Living Wills

Aadritha Das in her discussion of the legitimacy of living wills or ADs, addresses issues with passive euthanasia. The freedom to decline life-saving treatment is guaranteed by the Supreme Court, and advance medical directives amplify this right. Hence, for the implementation of ADs, the Bill must provide a legal framework. (Das Aadrita, 2017) From the perspective of the patient, the purpose of ACPs goes beyond getting ready for disability and encompasses preparing for one's eventual passing. It is not solely centred on asserting autonomy and control but also considers personal connections and alleviates the burdens imposed on others. (Singer et al., 1998)

Bioethical Principles

Beauchamp and Childress proposed four principles of Bioethics, Respect for autonomy, fairness, beneficence, and non-maleficence. (Beauchamp Tom L & Childress James F, 2001; Gillon R, 1994) The author explains in cases of terminal cancer; palliative treatment is essential, and the various facets of palliative care related to end-of-life concerns, such as pain and symptom management, psychological care, and others, should be handled ethically by abiding by ethical principles. (Mohanti, 2009)

Role of Medical Professionals in End-of-life

The role of the professionals caring for patients near the end of their lives is more important in ensuring that they receive the care and assistance they require. Many factors may have an impact on each professional's knowledge and attitude in providing care at the end of the life of a patient. Doctors play an integral role in providing EoLC as they are instrumental in discussing EoL issues by initiating the discussion, clarifying the prognosis, developing a treatment plan and identifying the EoL goals that are consistent with the wishes of the patient and their family members. (Balaban, 2000) At times doctors have to deal with demands to hasten death as well as practices where death is a predictable consequence. The attending physicians' understanding and awareness of the EoLC principles have a significant impact on the efficacy of the care they provide. Alleviating the suffering and pain is the main aim of End-of-life care and also a primary justification for euthanasia as death is

preferable to suffering. End-of-life decisions can be made by patients and their families, but doctors are an important part of the process.

Research Gap

The researcher conducted a comprehensive review of studies on end-of-life care and euthanasia. The findings revealed there is a paucity of information on EoL issues including EoLC, euthanasia and advance directives amongst the healthcare providers in India. The results of studies on Euthanasia revealed euthanasia was preferred in most studies but the review of the literature indicated that studies on euthanasia and EoLC were not conducted concurrently, though they are interconnected and can influence each other. Additionally, it was noted most of the studies were not focused on advance directives or on the level of comfort in providing EoLC. Oncology social workers play an important role in the care at end-of-life for cancer patients and their caregivers. However, the researcher observed few studies addressing end-of-life issues within the field of social work in India. Hence these research gaps highlight the need to investigate the perceptions of doctors on EoLC and Euthanasia with reference to terminally ill cancer patients.

III RESEARCH METHODOLOGY

3.1 Aim of the Study

This study aims to explore and understand the perception of doctors on End-of-Life Care and Euthanasia with reference to Terminally Ill cancer patients. The study seeks to examine the various features of doctors' perceptions on EoLC and Euthanasia, their association, correlation, differences, and influences between various demographic profiles.

3.2 Objectives

- To explore perceptions of Doctors on End-of-life Care with reference to terminally ill cancer patients
- To explore perceptions of Doctors on Euthanasia with reference to terminally ill cancer patients
- To compare and contrast the perceptions on End-of-life Care among Doctors
- To compare and contrast the perceptions on Euthanasia among Doctors
- To assess the perceptions of doctors with their demographical profile
- To determine the perception differences based on cultural context
- To analyse the association between perceptions of Doctors towards End-of-Life Care and perceptions towards Euthanasia.

3.3. Hypothesis of the study

To fulfil the objectives of the study the following hypotheses were framed:

H1: There is a significant association between various domains of perception on EoLC and various domains of perception on Euthanasia.

H2: There is a significant difference in the Knowledge and attitude towards EoLC, Perception towards the Level of Comfort on EoLC, Perceptions towards Advance Care Planning and Advance Directives between doctors' various demographic variables.

H3: There is a significant difference in the Attitudes towards Euthanasia, Perceptions towards Legalisation of Euthanasia/PAS, and Perceptions on reasons favouring/not favouring Euthanasia between doctors' various demographic variables.

H4: There is a correlation between the perceptions of Doctors towards End-of-Life Care and Euthanasia.

H5: The Demographic factors as well as Knowledge and attitude on EoLC and Perception towards the Level of Comfort on EoLC have an impact on the Perceptions of doctors towards Advance Care Planning and Advance Directives.

H6: The Demographic factors as well as Attitudes towards Euthanasia and Perceptions on Reasons favouring and not favouring Euthanasia have an impact on the Perceptions towards the Legalisation of Euthanasia/PAS.

H7: The positive perceptions of Doctors towards End-of-Life Care will exhibit negative perceptions towards Euthanasia and vice versa.

H8: The demographic variables, knowledge and attitude towards EoLC, perception towards level of comfort on EoLC, perception on advance care planning and advance directives and attitude towards Euthanasia, and perception on reasons favouring or not favouring euthanasia significantly influence the perception on legalisation of Euthanasia.

3.4 Research Design

A descriptive study is concerned with existing circumstances, practises, structures, differences, or associations, as well as viewpoints, procedures, or trends. Based on the objectives of the current study a descriptive design is used to describe the perception of doctors related to end-of-life care and euthanasia.

3.4.1 Universe of the Study

The universe of the study encompasses doctors practicing in tertiary care hospitals that provide comprehensive cancer care treatment services in the districts of Coastal Karnataka. Coastal Karnataka comprises three districts: Dakshina Kannada, Udupi, and Uttara Kannada.

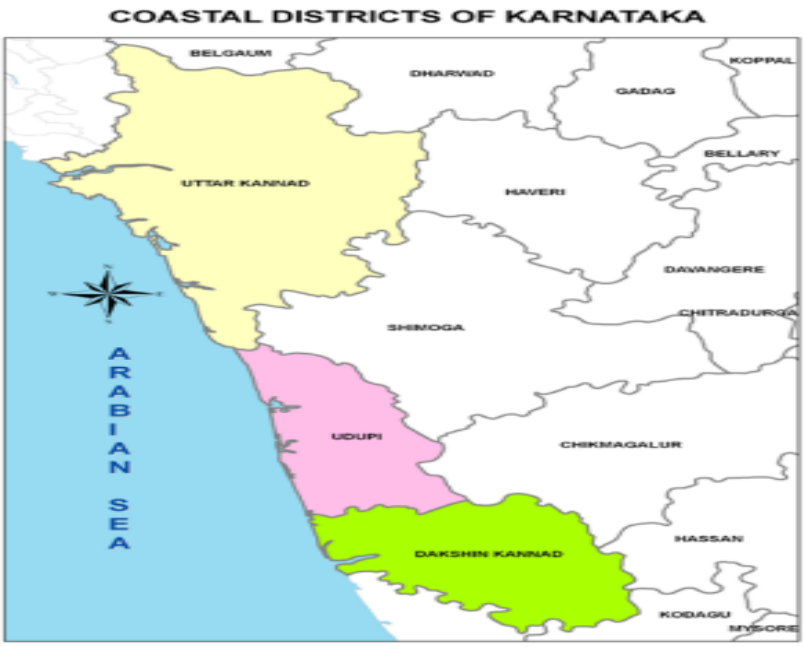

Figure 3.1 Geographical Map of Coastal Karnataka

3.4.2 Sampling Techniques:

The study used a multi-stage sampling technique to identify the respondents. In the first stage of the cluster sampling method, the Hospitals from Udupi, Dakshina Kannada, and Uttara Kannada are considered for the study. In the second stage, hospitals are divided into different strata based on the criteria stated above. The respondents are then selected using a random sampling technique and ensured the representative character of the total sample is included.

Table 3.1: The number of tertiary care hospitals providing comprehensive Cancer Care in the districts of Coastal Karnataka

Districts	**Government Hospitals**		**Private Hospitals**	
	Tertiary Care Hospitals	Hospitals with Comprehensive Cancer Care	Tertiary Care Hospitals	Hospitals with Comprehensive Cancer Care
Dakshina Kannada	01	--	18	06
Udupi	01	--	06	01
Uttara Kannada	01	--	--	--
Total Hospitals with Comprehensive Cancer Care				**07**

Sample size: The sample size was determined using the software G*Power. By applying Power Analysis with α=0.05, effect size =0.3, and power = 0.95 sample size turned out to be 248.

The formula used is for sample size calculation:

$$n=2\,\frac{(Z_{1-\alpha/2}+Z_{1-\beta})^2\sigma^2}{\delta^2}$$

Number of doctors in hospitals with comprehensive cancer care services in Dakshina Kannada & Udupi	650
Sample Size by applying Power Analysis with α=0.05, effect size =0.3, and power = 0.95	**248**

3.4.3 Research Instrument

The researcher developed a structured questionnaire based on the study objectives, taking insights from the previous literature.(Catt et al., 2005; N. I., Cherny & Catane, 2003; N. I. Cherny & Catane, 2003; Csikos et al., 2010; Grassi et al., 1999; Hui et al., 2016; Kaur, 2014; Kwon, 2012; Sandeep et al., 2007; Sethi Rajesh, 2015; Wasserman et al., 2005) The questionnaire was comprised of closed-ended questions consisting of three sections with the following domains:

A: Socio-demographic Data

Respondents' characteristics: Consisted of 13 statements which included respondents' Biographical details, details on professional qualification, and Experience/practice-related information of respondents.

B. Perceptions of Doctors on End-of-Life Care (EoLC): is measured by the following domains:

- **Knowledge and Attitude towards EoLC**: consisted of 14 statements that were measured using five-point Likert scale, where 1-strongly disagree, 2-disagree, 3-neutral, 4-agree, and 5-strongly agree.
- **Perceptions towards Level of comfort towards EoLC**: 14 statements were evaluated using a five-point Likert scale where 1-strongly disagree, 2-disagree, 3-neutral, 4-agree, and 5-strongly agree.
- **Perceptions towards Advance Care Planning and Advance Directive:** This domain with 7 statements was assessed using a five-point Likert scale where 1-strongly disagree, 2-disagree, 3-neutral, 4-agree, and 5-strongly agree.

C. Perception of Doctors on Euthanasia/Physician-Assisted Suicide (PAS): is measured by the following domains:

- **Attitude towards Euthanasia (ATE Scale-)** (Wasserman et al., 2005): consisted of 10 statements that were measured by using a five-point Likert scale where 1-strongly disagree, 2-disagree, 3-undecided, 4-agree, and 5-strongly agree.
- **Perceptions on Reasons favouring or not favouring Euthanasia:** This domain with 8 statements was evaluated by using a four-point Likert scale where 1-strongly disagree, 2-disagree, 3-agree, and 4-strongly agree
- **Perceptions towards Legalisation of Euthanasia/PAS**: This domain with 7 statements was assessed by using a four-point Likert scale where 1-strongly disagree, 2-disagree, 3-agree, and 4-strongly agree.

3.4.4 Validation

The formulation of questions was significantly guided by insights from the literature. The substance of the questionnaire was driven by pertinent questions presented by notable researchers and derived from their relevant questionnaires. It was subjected to a thorough peer review by the expert panel consisting of Radiation Oncologists, a Medical Oncologist, a Pain & Palliative Physician and an Academician for validation. The questionnaire was subsequently modified as per the suggestions of the panel.

3.4.5 Sample Selection: The inclusion and exclusion criteria followed were as follows:

Inclusion criteria:

- All Doctors practicing allopathy medicine with MBBS and above qualification
- Doctors practicing in Tertiary care hospitals with comprehensive cancer care.

Exclusion criteria:

- Doctors who are not directly engaged in the care of patients (para-clinical)
- Doctors practicing alternative medicine (Ayurveda, Homeopathy, Unani etc.)
- The study comprises only the doctors and does not include other healthcare professionals.

3.4.6 Pilot survey

The questionnaire was piloted in an attempt to assess to test the reliability of the items in the questionnaire under various independent variables. The questionnaire was administered to 75 doctors representing the pilot study. When the reliability coefficient is 0.9 or greater, it is concluded that the data collected by the researcher is

reliable and can move ahead with the main survey. Cronbach's Alpha reliability coefficient is calculated for the respondents' responses to all the questions in the Likert scale under various categories in the questionnaire. The alpha reliability coefficient for all the components is greater than 0.90 and hence retained all the items under various domains of perceptions towards End-of-Life Care and Euthanasia in the questionnaire.

3.4.7 Primary Study

After the pilot study the primary study is carried on and data is collected from 248 doctors on the perception on End-of-Life care and Euthanasia.

Test of Reliability of Data

Reliability analysis allows researchers to study the properties of measurement scale and the items. The reliability analysis procedure calculates a number of commonly used measures of scale reliability and also provides information about the relationship between individual items in the scale.

3.4.7.1 Cronbach Alpha

Cronbach's Alpha reliability coefficient is used to find out how far the data collected by using Likert's Five Point Scale are reliable. The reliability coefficient ranges from 0 to 1. A reliability coefficient of 0.7 or greater is generally said to be reliable in literature. When the reliability coefficient is 0.7 or greater then it is concluded that the data collected by the researcher is reliable and can be used for further analysis. Cronbach's Alpha reliability coefficient is calculated for the respondents' responses to all the questions in the Likert scale under various categories in the questionnaire and it is seen that the alpha reliability coefficient is greater than 0.8 and hence the data collected by the researcher is used for different statistical analyses as per the objectives framed for the analysis.

3.5 Method of data collection

Primary Data: The researcher collected primary data through a structured questionnaire. Participants were requested to rank their responses to the specific questions by making use of the 5-point Likert Scale.

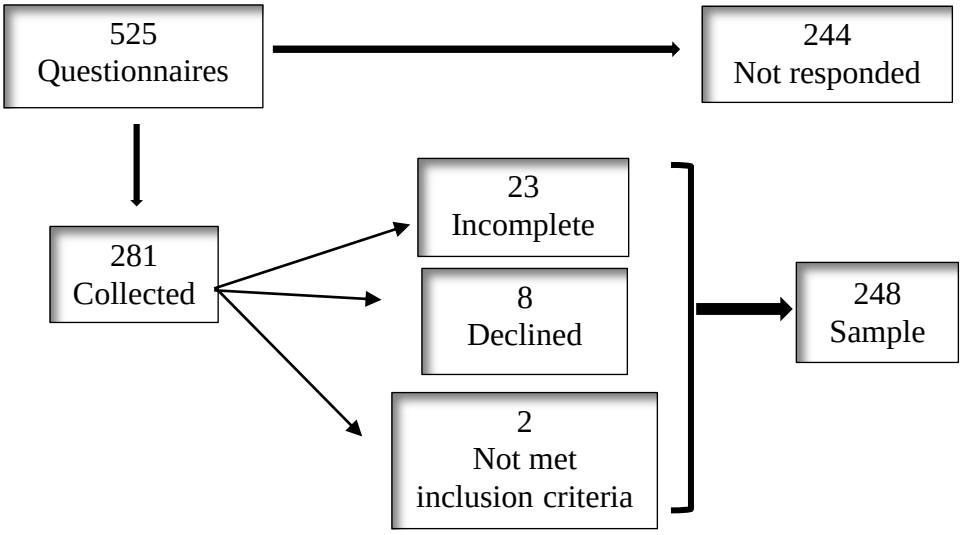

Figure 3.2 Data Collection Process

Secondary Data

The relevant literature for the current research is compiled from various sources.A systematic search was conducted across major academic databases to ensure a comprehensive review, resulting in a curated collection of peer-reviewed articles, journals, qualitative and quantitative studies, thesis surveys, and interviews.

3.6 Statistical methods for data analysis

The perceptions of doctors on End-of-Life care and Euthanasia have been analysed with descriptive and inferential statistical analyses. Descriptive statistics is used to explore the characteristics of the collected information and inferential analysis is to infer from the sample data in the form of testing of hypothesis.

The data was analysed by using Statistical Packages for Social Science (SPSS) 23.0. To test the hypothesised (Conceptual) model Structural Equation Modelling (SEM) was carried out using SPSS AMOS 23.0 software.

3.7 Ethical Consideration

Research safety and integrity depend on ethical considerations. To preserve participants' rights, privacy, and anonymity ethical considerations were observed during the data collection phase. The purpose and aim of the study were explained to the participants of the study. Before filling out the questionnaire participants were given informed consent to ensure their right either to voluntarily participate or reject to participate in the study. The participants gave informed consent while maintaining their anonymity and confidentiality. The participants were assured of the

confidentiality of the information given and the collected data would be used only for academic purposes.

3.8 Limitations of the Study

Doctors were well-established professionals and due to their busy schedule, the collection of data took a longer period of time.

3.9 Layout of the Study: The entire research work of the current study will run into five chapters

Chapter I: Introduction: This chapter deals with the introductory part of the study and introduces different factors related to the study. The chapter also gives background of the study, a statement of the problem, Research questions, the need of the study and the conceptual model.

Chapter II: Review of Literature: The chapter reviews the previous studies from national and international literature. It delves into the literature from various sources such as journals, theses, books, and websites. The studies on end-of-life care and euthanasia and the perception of doctors are discussed.

Chapter III: Research Methodology: This chapter states the aim, objectives and hypothesis of the study. It involves standardized procedures and processes that are followed by the researcher in fulfilling the pre-established objectives of the research.

Chapter IV: Analysis and Interpretation: This chapter is the core of the whole research because it deals with the outcome of the study. The chapter focuses on the analysis of the objectives of the study and presents the interpretations.

Chapter V: Findings, Discussion, Recommendations and Conclusion: This chapter mainly focuses on major findings, conclusions, suggestions based on the findings and a discussion of findings in the light of the studies reviewed earlier.

IV Summary of Major findings of the study

4.1 Findings Related to the Demographic Profile of the Respondents

- The study finds majority of the respondents i.e., 41.5% belong to the age group of 30-39 years with 60.5%, a major representation from the male category and 71% of them were married.
- The study shows a majority of 29% of participants with MD qualifications and most of the participants, around 17.3% were Radiation Oncologists.
- The study revealed 24.6% of respondents with overall years of practice of 6-10 years, 47.5% of doctors have seen less than 25 percentage of terminally ill patients in their clinical practice and around 23.4% of the doctors have addressed the patients and their families with End-of-Life Care for 1-5 years.

4.2 Descriptive Statistics

- The descriptive analysis revealed the overall mean score for Knowledge and Attitude towards End-of-life Care was 4.08 with an average variation of 0.862 (4.08 ± 0.862),
- The respondents agreed to the factors mentioned under the parameters of Perception towards the Level of Comfort on End-of-life Care with an overall mean score of 3.56 and average variation of 1.004 (3.56 ± 1.004).
- The analysis showed on average that Perceptions towards Advance Care Planning and Advance Directives is considered respondents agreed to the factors mentioned under the parameter with an overall mean score of 3.86 and an average variation of 0.812 (3.86 ± 0.812).
- The study revealed as far as Attitudes towards Euthanasia are concerned respondents were undecided about the factors mentioned under the parameter with an overall mean score of 2.77 and an average variation of 1.566(2.77 ± 1.566).
- Towards the Perceptions towards the Legalisation of Euthanasia/PAS are considered respondents agreed to the factors mentioned under the parameter with an overall mean score of 2.75 and average variation of 0.877(2.75 ± 0.877).
- The descriptive analysis as far as Perceptions on Reasons favouring/not favouring Euthanasia are considered respondents agreed to the factors mentioned under the parameter with an overall mean score of 2.64 and average variation of 0.794 (2.64 ± 0.794).

4.3 Factor Analysis

- The components of Perceptions on EoLC and Perceptions on Euthanasia have KMO values greater than 0.7 and Bartlett's test significance value (p-value) for all the components is less than 0.01.
- From factor analysis, 3 components were extracted from Knowledge and attitude towards EoLC. The maximum communality value is explained by the variable "All cancer centres should have a palliative care service." with the value 0.735.
- Five components were extracted from factor analysis from Perception towards the Level of Comfort on End-of-life Care. The maximum communality value is explained by the variable "Discussing a prognosis with patients gives them a sense of hopelessness" with a value of 0.794.
- From perceptions towards advance care planning and advance directives, 2 components were extracted. The maximum communality value is explained by the variable "It is important to make plans on, future medical care through advance directives/living wills." with a value of 0.795.
- From Factor analysis of attitudes towards euthanasia, 3 components were extracted. The maximum communality value is explained by the variable "It is okay for a doctor to remove life-support and let a patient die if the doctor does not believe the patient will recover" with a value of 0.876.
- Two components were extracted from Factor analysis of Perceptions towards the Legalisation of Euthanasia/PAS. The maximum communality value is explained by the variable "The legalisation of Euthanasia or PAS may prove a slippery slope in India" with the value 0.878.
- From Factor analysis on perceptions on reasons favouring/not favouring euthanasia 3 components were extracted. The maximum communality value is explained by the variable "More attention to quality-of-life concerns would eliminate the need for euthanasia" with the value 0.878.

4.4 Karl Pearson's Correlation Coefficient

- There is a significant positive correlation between Overall years of practice and Knowledge and attitude towards EoLC ($r=0.221$; $p<0.01$), Overall years of practice

and Perceptions towards Advance Care Planning and Advance Directives ($r=0.178$; $p<0.05$),

- It is evident that there exists a significant negative correlation between Overall years of practice and Attitudes towards Euthanasia ($r=-0.180$; $p<0.01$) and Overall years of practice and Perceptions on Reasons favouring Euthanasia ($r=-0.126$; $p<0.05$),
- The study revealed significant positive correlation between Percentage of terminally ill patients seen in clinical practice and Knowledge and attitude towards EoLC ($r=0.281$; $p<0.01$), Percentage of terminally ill patients seen in clinical practice and Perception towards Level of Comfort on EoLC ($r=0.265$; $p<0.01$), Percentage of terminally ill patients seen in clinical practice and perception on Reasons not favouring Euthanasia ($r=0.206$; $p<0.01$),
- The study found there exists a significant negative correlation between the Percentage of terminally ill patients seen in clinical practice and Perception on Reasons favouring Euthanasia ($r=-0.145$; $p<0.05$)
- A significant positive correlation was found between the Duration of addressing patients and their families with EoLC and Knowledge and Attitude towards EoLC ($r=0.229$; $p<0.01$), Duration of addressing patients and their families with EOLC and Perceptions towards Advance Care Planning and Advance Directives ($r=0.194$; $p<0.01$)
- A significant negative correlation between the Duration of addressing patients and their families with EoLC and Attitudes towards Euthanasia ($r=-0.214$; $p<0.01$) and Duration of addressing patients and their families with EoLC and Perceptions towards favouring Euthanasia ($r=-0.218$; $p<0.05$)

From the correlation analysis it is observed that as the experience of doctors increases, there is an increase in the Knowledge and attitude towards EoLC, Perception towards Level of Comfort on EoLC and Advance Care Planning and Advance Directives variables. Whereas, as the experience of doctors increases, Attitudes towards Euthanasia, Perceptions towards the Legalisation of Euthanasia/PAS, and Perception on Reasons favouring and not favouring Euthanasia decreases significantly.

Table 4.1: Findings of the Kruskal-Wallis H test

Findings of Kruskal Walis H Test on Perception of EoLC and Euthanasia			
Grouping Variable	**Variable on Perception of EoLC and Euthanasia**	**p-value**	**Impact**
Speciality	Knowledge and attitude towards EoLC	<0.01	A significant impact of Speciality on the Perceptions on End-of-Life Care
	Perceptions towards the level of comfort on EoLC		
	Perceptions towards Advance Care Planning and Advance Directives		
	Perceptions on Reasons favouring Euthanasia	<0.05	A significant impact of Speciality on the Perceptions on Reasons favouring as well as not favouring Euthanasia.
	Perceptions on not favouring Euthanasia		
Religious affiliation	Perception towards Level of Comfort on EoLC	<0.05	A significant impact of Religious affiliation on the Perception towards Level of Comfort on EoLC
	Attitude towards Euthanasia	<0.05	A significant impact of Religious affiliation on the perceptions on Euthanasia/PAS
	Perception towards Legislations of Euthanasia/PAS		
	Perceptions on Reasons favouring/ not favouring Euthanasia		
Marital Status	Knowledge and attitude towards EOLC	<0.05	A significant impact of Marital status on the Knowledge and attitude towards EoLC and Perceptions towards Advance Care Planning and Advance Directives
	Perceptions towards Advance Care Planning and Advance Directives		
Overall years of experience	Knowledge and attitude towards EOLC	<0.05	A significant impact of Overall years of experience on the Perceptions on EoLC
	Perception towards Level of Comfort on EOLC		
	Perceptions towards Advance Care Planning and Advance Directives		
	Attitude towards Euthanasia	<0.05	A significant impact of Overall years of practice on Attitude towards Euthanasia, Perceptions on Reasons
	Perceptions on Reasons favouring/not favouring		

	Euthanasia		favouring/not favouring Euthanasia
Duration of addressing patients & families with EoLC	Knowledge and attitude towards EoLC	<0.01	A significant impact of the duration of addressing patients & their families with EoLC on the Perceptions of EoLC
	Perception towards Level of Comfort on EOLC		
	Perceptions towards Advance Care Planning and Advance Directives		
	Attitude towards Euthanasia	<0.05	A significant impact of the Duration of addressing the patients and Perception of Euthanasia/PAS.
	Perception towards Legislations of Euthanasia/PAS		
	Perceptions on Reasons favouring Euthanasia		
Age	Knowledge and attitude towards EoLC	<0.01	A significant impact of age on the attitude and knowledge on EoLC.

4.5 Mann Whitney U - Test

- Gender has no influence on the perceptions related to EoLC and Euthanasia but has a significant impact on Perception towards reasons favouring Euthanasia at a 5% level of significance as p values are lesser than 0.05. Female doctors are more favourable towards reasons favouring Euthanasia as compared to male doctors.
- The study revealed there exists a significant difference in the Knowledge and Attitude towards EoLC, Perception towards Level of Comfort on EoLC, Perception towards Favouring Euthanasia and Perception towards not favouring Euthanasia between Oncologists and Non-oncologists at 5% level of significance as p values are less than 0.05.
- The study found Oncologists are more favourable towards Knowledge and attitude towards EoLC, Perception towards Level of Comfort on EoLC, and Perception towards not favouring Euthanasia as compared to Non-oncologists. However, it was found as far as Perception towards favouring Euthanasia is concerned non-oncologists are more favourable than oncologists.

4.6 Spearman's correlation

- The study found a significant positive correlation between knowledge and attitude towards EoLC and Perception towards Level of Comfort on EoLC ($r=0.325$, $p<0.01$), knowledge and attitude towards EoLC and Perceptions towards Advance Care Planning and Advance Directives ($r=0.433$, $p<0.01$) but there exists a significant negative correlation between knowledge and attitude towards EoLC and Attitudes towards Euthanasia ($r=-0.140$, $p<0.05$).
- The analysis revealed significant positive correlation between Perception towards the Level of Comfort on EoLC and Perceptions towards Advance Care Planning and Advance Directives ($r=0.332$, $p<0.01$) as well as between Perception towards the Level of Comfort on EoLC and Perceptions on Reasons not favouring Euthanasia ($r=0.229$, $p<0.01$).
- The study observed a significant positive correlation between Perceptions towards Advance Care Planning and Advance Directives and Perceptions towards Legalisation of Euthanasia/PAS ($r=0.153$, $p<0.05$) and a significant negative correlation between Perceptions towards Advance Care Planning and Advance Directives and Perceptions on Reasons not favouring Euthanasia ($r=-0.135$, $p<0.05$).

- There exists a significant positive correlation between Attitude towards Euthanasia and Perceptions towards Legalisation of Euthanasia/PAS ($r=0.285$, $p<0.01$) as well as between Attitude towards Euthanasia and Perceptions on Reasons favouring Euthanasia ($r=0.312$, $p<0.01$).
- There is a significant positive correlation between Perceptions towards Legalisation of Euthanasia/PAS and Perceptions on Reasons favouring Euthanasia ($r=0.230$, $p<0.01$) and a significant negative correlation between Perceptions towards Legalisation of Euthanasia/PAS and Perceptions on Reasons not favouring Euthanasia ($r=-0.196$, $p<0.01$).

4.7 Multivariate Regression Analysis

- It is observed that there is a positive slope coefficient, for the independent variables duration of addressing the patients which increases the Perceptions of doctors towards Advance Care Planning and Advance Directives on an average by 0.097. If the Perception towards the Level of Comfort on EOLC improves the Perceptions of doctors towards Advance Care Planning and Advance Directive on an average would increase by 0.160 respectively keeping other variables constant, statistically significant at a 1% level.
- It is observed that there is a positive slope coefficient for the independent variables' Attitude towards Euthanasia and Perceptions on Reasons favouring Euthanasia. The increase in the Attitude towards Euthanasia and Perceptions on Reasons favouring Euthanasia, increases the Perceptions of doctors towards the Legalisation of Euthanasia/PAS on an average by 0.177 and 0.223 respectively keeping other variables constant, statistically significant at 1% level.
- It is noticed that there is a negative slope coefficient for the independent variable Religious Affiliation and Perceptions on Reasons not favouring Euthanasia. If the religious affiliation and Perceptions on Reasons not favouring Euthanasia changes the Perceptions of doctors towards the Legalisation of Euthanasia/PAS on average would decrease by 0.111 and 0.209 respectively.

4.8 Path Analysis

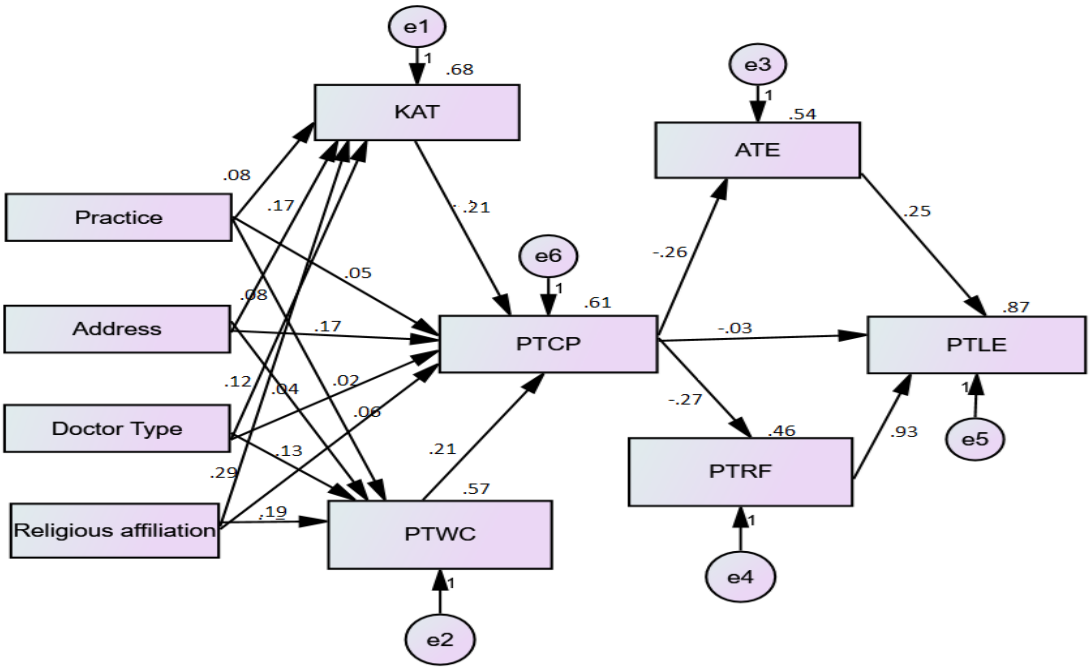

Figure 4.1: Path Model for Perceptions of Doctors Towards Legalisation of Euthanasia/PAS

In summary, the given percentages of explained variation highlight the significant impact of various factors on doctors' perceptions on various domains of end-of-life care and euthanasia. These findings offer valuable insights into the intricacies of doctors' perceptions in these domains.

5. Strengths of Study:

The study's emphasis on doctors' perception of terminally ill cancer patients, addresses a highly relevant and sensitive medical problem. Understanding doctors' perceptions might give insights into the issues they confront and how they negotiate these delicate circumstances. This may draw the interest of both medical experts and the general public, potentially leading to increased impact and awareness. By providing a platform for transparent conversations, the study can contribute to more informed decision-making. As the study used a varied sample of doctors from various specialisations, cultural backgrounds, and healthcare settings, it may improve the validity and generalizability of the study. It has recorded a variety of viewpoints and experiences of doctors. The study's findings can be used to discuss the policy and legal debates around euthanasia and end-of-life care. Understanding the perceptions

of healthcare professionals may help policymakers when drafting laws and regulations.

In social work education and practice, the study provides a premise to understand the issues related to end-of-life care and euthanasia, their role in end-of-life issues and how they may prepare themselves for their future endeavours.

6. Directions for Future Studies in Social Work Research:

- Research studies may be undertaken to assess terminally ill patients and their caregivers' outlooks on care at end-of-life to contrast doctors' perceptions and to develop policies that facilitate EoL discussions.
- Exploring the perception or knowledge and attitudes of social workers towards issues related to end-of-life.
- Conducting Comparative studies on different segments of the community like lawyers, doctors, nurses or the general public on end-of-life care and euthanasia
- Research into studies that analyse End-of-Life Care and Social Work Interventions
- Interventional studies to evaluate the coping mechanisms adopted by patients and their caregivers as they confront the challenges of terminal illnesses.
- Studies on the perceived impact of Advance Care Planning and the desirability of Euthanasia in India.

7. Social Work Implications:

The current study has several important implications for social work These implications can impact how social workers collaborate with medical professionals, support patients and their families, and advocate for the best possible care and decisions in end-of-life situations by integrating social work methods and approaches.

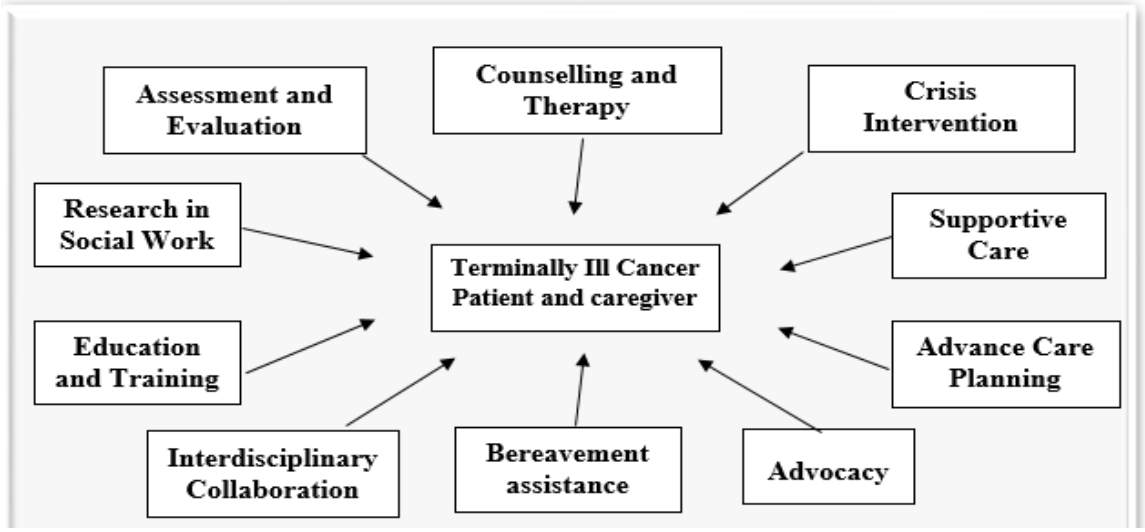

Figure 7.1: Social Work Implications

8. Recommendations

- Medical training programs should include a curriculum on palliative care for doctors during their undergraduate and post-graduation studies.
- To prevent structural barriers in delivering the EoLC, the government must consider setting up institutions providing palliative and end-of-life care
- Government should develop clear legal frameworks on end-of-life care, euthanasia and guidelines on Advance Care Planning.
- Doctors should promote Advance Care Planning to prevent futile EoLC with aggressive treatments which lead to unnecessary suffering for patients and financial burdens for families.
- All hospital settings must have an EoLC policy to provide comprehensive and holistic EoLC to terminally ill patients and their caregivers.
- Educational training is very important for social workers to achieve competency in providing qualitative care at EoL. Therefore, the curriculum of social work education must include various domains of EoLC and Euthanasia.
- Social workers can be involved in the policy-making process of euthanasia and end-of-life care, taking into account ethical, social, psychological, and practical factors. Their contributions are essential to the creation of effective, moral, and compassionate policies that uphold the autonomy and dignity of those dealing with these delicate challenges.

9. Conclusion

Every beginning has an end. Similarly, every life which begins from the womb of a mother has an end with a tomb. It is desired and agreed by all that everyone prefers a peaceful death without sufferings. Doctors play a pivotal role in enabling patients and their caregivers to experience rather without much physical, emotional, and financial suffering. The study found doctors showed their agreeableness towards various domains of EoLC. Whereas they were indecisive on Euthanasia. Doctors favoured euthanasia on the grounds of extreme suffering of patients provided it is legalised and guided with proper regulation to avoid abuse.

It can be concluded that there is a significant difference in the perception of Doctors on End-of-Life Care and Euthanasia and the Demographic profile of doctors play a vital role in the perception of doctors.

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